STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005044	A. BUILDING: _____ B. WING _____	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REID HOSPITAL & HEALTH CARE SERVICES	1100 REID PKWY RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of a State complaint. Complaint Number: IN00143800 Unsubstantiated: Lack of sufficient evidence. Facility Number: 005044 Date of Survey: 07/31/2014 Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor Reid Hospital & Health Care Services is in compliance with 410 IAC 15-1.5-6, Nursing services and 410 IAC 15-1.6.2, Emergency services, Hospital Licensure Rules. QA: claughlin 08/05/14	S 000		